907 KAR 1:104. Reimbursement for advanced practice registered nurse services.

RELATES TO: KRS 205.520, 314.011, 42 C.F.R. 438.2, 42 U.S.C. 1396s

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement provisions and requirements regarding services provided to Medicaid recipients who are not enrolled with a managed care organization by individual advanced practice registered nurses (APRNs) enrolled in the Medicaid program or APRN provider groups enrolled in the Medicaid program.

Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Department" means the Department for Medicaid Services or its designated agent.

(3) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

(4) "Physician administered drug" or "PAD" means any rebateable covered outpatient drug that is:

(a) Provided or administered to a Medicaid recipient;

(b) Billed by a provider other than a pharmacy provider through the medical benefit, including a provider that is a physician office or another outpatient clinical setting; and

(c) An injectable or non-injectable drug furnished incident to provider services that are billed separately to Medicaid.

(5) "Provider group" means a group of at least two (2) individually licensed APRNs who:

(a) Are enrolled with the Medicaid Program individually and as a group; and

(b) Share the same Medicaid group provider number.

(6) "Usual and customary charge" means the uniform amount the provider charges in the majority of cases for the service or procedure.

Section 2. Reimbursement. (1) The department’s reimbursement under this administrative regulation shall be for a service or procedure:

(a) Covered pursuant to 907 KAR 1:102; and

(b) Provided by an APRN or APRN provider group that:

1. Meets the condition of participation requirements established in 907 KAR 1:102, Section 2; and

2. Is the billing provider for the service or procedure.

(2) Except as specified in subsection (3) of this section or Section 3 of this administrative regulation, the department shall reimburse for a service or procedure that is covered pursuant to 907 KAR 1:102 at the lesser of:

(a) The APRN's or APRN provider group’s usual and customary charge for the service or procedure; or

(b) Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service or procedure pursuant to 907 KAR 3:010.

(3) The department’s reimbursement for a behavioral health service covered pursuant to 907 KAR 15:010 that is provided by an APRN or APRN provider group that is the billing provider for the service shall be pursuant to 907 KAR 15:015.

Section 3. Reimbursement Limitations. (1) The department shall reimburse an APRN or APRN provider group:

(a) A three (3) dollar and thirty (30) cent fee for each vaccine administered to a Medicaid recipient under the age of nineteen (19) up to a maximum of three (3) administrations per APRN, per recipient, per date of service; and

(b) The cost of each vaccine administered in accordance with paragraph (a) of this subsection, except as established in subsection (2) of this section.

(2) The department shall not reimburse for the cost of a vaccine that is available free through the Vaccines for Children Program in accordance with 42 U.S.C. 1396s.

(3) The department shall reimburse for a PAD in accordance with 907 KAR 23:020.

(4)

(a) Payment for a cast or splint applied in conjunction with a surgical procedure shall be included in the payment for the surgical procedure.

(b) Except as provided by paragraph (c) of this subsection, the department shall not reimburse for a cast or splint application for the same injury or condition within ninety (90) calendar days:

1. From the date of the surgical service; or

2. If surgery is not performed, from initial application of the cast or splint.

(c) The department shall reimburse for a second cast or splint applied for a subsequent injury or condition within ninety (90) calendar days of the first cast or splint application if the claim contains documentation demonstrating that the injury or condition occurred subsequent to the initial cast or splint application.

(d) Reimbursement for the application of a cast or splint associated with a surgical procedure shall be considered to include:

1. A temporary cast or splint, if applied by the same physician who performed the surgical procedure;

2. The initial cast or splint applied during or following the surgical procedure; and

3. A replacement cast or splint needed as a result of the surgical procedure if:

a. Provided within ninety (90) calendar days of the procedure by the same physician; and

b. Applied for the same injury or condition.

(5) Reimbursement for an anesthesia service provided during a procedure shall include:

(a) Preoperative and postoperative visits;

(b) Administration of the anesthetic;

(c) Administration of intravenous fluids, blood, or blood products incidental to the anesthesia or surgery;

(d) Postoperative pain management; and

(e) Monitoring services.

(6) The department's reimbursement for a laboratory service provided in an office setting shall include the fee for collecting and analyzing a specimen.

(7) A fee for a laboratory test requiring an arterial puncture or a venipuncture shall include the fee for the puncture.

Section 4. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 1:102; and

(2) This administrative regulation.

Section 5. Federal Approval and Federal Financial Participation. The department's reimbursement of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 6. Appeal Rights. An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671. (17 Ky.R. 2366; eff. 5-3-1991; Am. 19 Ky.R. 1454; eff. 1-27-1993; 27 Ky.R. 247; 812; eff. 9-11-2000; TAm 4-28-2011; 44 Ky.R. 395, 1355; eff. 1-5-2018.)